Ken Taylor, D.D.S., F.A.G.D

Patient Information

Patient's Name _____
Last First Middle Nickname

Address _____
Street City State Zip

E-mail Address _____

Home Ph. _____ Work Ph. _____ Cell Ph. _____

Birth Date ____/____/____ Social Sec. # _____ Drivers Lic. # _____

Marital Status ____Male ____Female ____Employer _____

Spouse's Name _____
Last First Middle

Spouse's Employer _____ Spouse's Work Phone _____

If patient is a minor, give parent's or guardian's name _____

Is an immediate family member a patient here? _____ Name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Self _____ Other _____
Yes/No Last First Middle

If "other," please complete:

Birth Date ____/____/____ Social Sec. # _____ Relationship to Patient _____

Address _____
Street City State Zip

Home Ph. _____ Work Ph. _____

Insurance Information

Primary Policy Holder's Name _____ Policy Holders Soc. Sec. # _____ Birth Date ___/___/___

Policy Holders Employer _____

Insurance Company _____ Group No. # _____ Phone No. # _____

Insurance Co. Address _____
Street City State Zip

Secondary Insurance Information

Secondary Policy Holder's Name _____ Secondary Policy Holders Soc. Sec. # _____ Birth Date ___/___/___

Secondary Policy Holders Employer _____

Insurance Company _____ Group No. # _____ Phone No. # _____

Insurance Co. Address _____
Street City State Zip

Authorization Information

Initial

1. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. _____
2. All insurance benefits will be directed to Dr. Ken Taylor, unless treatment paid in full at time of service. _____
3. I give my consent for photographs to be taken for teaching and presentation purposes. _____
4. As long as I am a patient of record, any of my records may be shared with other doctors for consultation and/or referral. _____

Signature (Parent's signature, if minor) _____ Date _____

Health History

Do You Have or Have You Ever Had:

Anemia ..... Yes ❑ No ❑
Diabetes ..... Yes ❑ No ❑
Allergies ..... Yes ❑ No ❑
Please List _____
_____
_____

Chronic Headaches ..... Yes ❑ No ❑
TMJ Problems ..... Yes ❑ No ❑
Abnormal Heart Condition ..... Yes ❑ No ❑
Heart Murmur ..... Yes ❑ No ❑
Mitral Valve Prolapse ..... Yes ❑ No ❑
High Blood Pressure ..... Yes ❑ No ❑
Abnormal Bleeding From a Cut ..... Yes ❑ No ❑
Rheumatic Fever ..... Yes ❑ No ❑
Hepatitis ..... Yes ❑ No ❑
❑ Type A ❑ Type B ❑ Non A/B
Tuberculosis ..... Yes ❑ No ❑
Have You Ever Had a Tumor, Cyst, Cancer? ..... Yes ❑ No ❑
Radiation or Chemotherapy ..... Yes ❑ No ❑

Have You Tested Positive For AIDS Virus/HIV? ..... Yes ❑ No ❑
Do You Use Tobacco? ..... Yes ❑ No ❑
Are You Pregnant? ..... Yes ❑ No ❑
Are you currently under a physician's care? ..... Yes ❑ No ❑
Please Detail: _____
_____
_____

Other Physical Conditions ..... Yes ❑ No ❑
Please Detail: _____
_____
_____
_____

Are You Taking Any Medication, Hormones, Vitamins, Birth Control? ..... Yes ❑ No ❑
Please Detail: _____
_____
_____
_____

Date of Last Medical Examination _____ Name of Physician _____
Date of Last Dental Visit / Exam _____ Name of Dentist _____
What is You Present Dental Problem or Concern? _____
_____

Do you like the color, size and shape of your teeth? Yes ❑ No ❑
If no, why not? _____
_____

Have you ever experienced any of the following?

Bleeding gums ..... Yes ❑ No ❑
Pain or soreness ..... Yes ❑ No ❑
Receding gums ..... Yes ❑ No ❑
Loose teeth ..... Yes ❑ No ❑

Bad breath or bad taste ..... Yes ❑ No ❑
Food packing between teeth ..... Yes ❑ No ❑
Grinding your teeth ..... Yes ❑ No ❑
Problem with snoring ..... Yes ❑ No ❑

Emergency Information

In case of an Emergence Notify _____ Phone# _____
Address _____
Street City State Zip
Pharmacy Name _____ Phone# _____

Ken Taylor, D.D.S., F.A.G.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent tour use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Lyn Brice Phone: 972.270.1515 Fax: 972.613.4776

Address: 2856 N. Galloway Ave., Mesquite, Texas 75150

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations, including sharing of any of my information with other physicians and/or dental personnel, as well as insurance companies and pharmacies.

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Insurance Notification

- I understand that my insurance policy is a contract between my insurance provider and myself, not between the insurance company and Ken Taylor, DDS.
- I also understand that insurance policies vary greatly from one policy to the next and that Ken Taylor DDS and staff are not responsible for knowing all the details of my policy.
- I understand that Dr. Taylor's staff is authorized by Dr. Taylor to file my insurance as a courtesy to me.
- I agree that my insurance policy is ultimately my responsibility, and that if the insurance company does not remit payment within 60 days the fees for the dental services provided becomes my sole responsibility. Then, upon request from Ken Taylor DDS, I will promptly remit payment and petition my insurance company on my own behalf.

_____ _____

Patient or responsible party signature Date

Ken Taylor, DDS FAGD
A Family Care Practice, Including Orthodontics
Office 972.270.1515
2856 N Galloway Ave
Mesquite, Texas 75150

CONSENT FOR INTERNET COMMUNICATIONS

Patient Name_____

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information, and clinical information) to the secured website for the dental practice. I understand that for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining strict confidentiality of any ID and password assigned to me; and the dental practice is not liable for any charges, damages, or losses that may be incurred for suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the practice will represent and warrant that they will, at all times during the term of the Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED, OR RECEIVED USING THE SITE FOR SERVICES.

_____ I have read the information above regarding the secured uploading of patient information to the website for the dental practice, and grant the dental practice permission to securely upload my patient information for the website,

_____I grant the dental practice permission to communicate with me through email.

_____I grant the dental practice to communicate with me via text messages.

Signature of patient, parent, or guardian

Signature_____Date_____

Relationship to patient, if not patient _____